

first name _____ last name _____
address _____ city _____ state _____ zip _____
phone _____ alt phone _____
caregiver name _____ troop #, leader _____
caregiver email _____

If the caregiver cannot be reached, the following person is authorized to act on their behalf:

name _____
address _____
city _____ state _____ zip _____
phone _____ alt phone _____

What illnesses, injuries, allergies or health conditions—if any—should we be aware of to best support your Girl Scout?

I do hereby authorize medical attention from a qualified and licensed medical doctor/healthcare provider in the event of a medical emergency, and the transportation to a medical facility if required.

I know of no reason(s) other than the information indicated on this form, why my Girl Scout should not participate in prescribed activities except as noted. If I cannot be reached in the event of any emergency, the troop leadership may act on my behalf by providing for emergency medical treatment and/or transportation.

Signature _____ Date _____

The following information is commonly requested by the emergency treatment facility:

Date of Birth (mm/dd/yyyy) _____
Last Tetanus (approx date) _____
Date of last health exam _____

Name of Insurance Provider (if any) Policy/Group #

COVID-19 is an extremely contagious virus that spreads easily through person-to-person contact. As with any social activity, participation in Girl Scouts could present the risk of contracting COVID-19. While GSSOAZ attempts to take every safety and preventative precaution, GSSOAZ can in no way warrant that COVID-19 infection will not occur through participation in GSSOAZ programs.

General Permission

_____ is my/our child in my/our legal custody. I/we have full authority to give this permission. My child has my/our permission to participate in all Girl Scout program and activities conducted or sponsored by Troop # _____, to which my child is registered, or which are conducted or sponsored by the Girl Scouts of Southern Arizona, Inc.

In case of sickness or accident, I/we, give permission for medical attention and the administration of medication and treatment as prescribed by the child's physician or as determined by an available physician, nurse, health professional or first aider.

My/our child needs or may need any of the following medications, i.e. inhaler, Epipen, dietary needs, or specific accommodations during their activity participation with heir troop or individually. Write "NONE" if there are none.

Physicians, nurses, health professionals or first aiders MAY NOT administer the following medicines or treatments. Write "NONE" if there are none.

When participating in Girl Scout activities, my child may be photographed for print, videotaped, or electronically imaged. Images may be used in promotional materials, news releases, and other published formats for either the local Girl Scout Councils or Girl Scouts of the USA. The images will be the sole property of either the local Girl Scout Council or Girl Scouts of the USA. I wish to opt out at this time.

Signature _____ Date _____